STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	R-C 04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	5226 E 82ND ST INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00086031 completed on March 9 2011. This visit was in conjunction with the Investigation of Complaints IN00088043, IN00088401, and IN00088559. Complaint IN00086031-Corrected. Survey dates: April 6, 7, 8, 9, 10, 11 2011 Extended survey dates: April 12, 13 2011 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Survey team: Chuck Stevenson, RN Christi Davidson, RN (4/06, 4/07, 4/08 2011) Census bed type: SNF/NF: 133 Total: 133 Census payor type: Medicare: 29 Medicaid: 76 Other: 28 Total: 133 Sample: 3 Kindred Transitional Care of Castleton was found to be in compliance with 42 CFR Part 483,Subpart B and 410 IAC 16.2 in regard to the	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 PSR to the Investigation of Complaint IN00086031. Quality review completed on April 18, 2011 by Bev Faulkner, RN	{F 000}		